

## Letters

### Paraplegia following oral hypotensive treatment of malignant hypertension

Sir: A 41 year old smoker was admitted to hospital with a two year history of headache and a five week history of painless haematuria. On examination his blood pressure was 200/140 mmHg supine and he had a grade IV hypertensive retinopathy. That evening he was given enalapril 2.5 mg and atenolol 100 mg. The following morning he complained of incontinence and severe weakness of his legs. On examination his blood pressure was 100/60 mmHg supine; there were no signs of an abdominal aneurysm and peripheral pulses were equal. He had absent abdominal reflexes and a spastic paraparesis with upgoing plantars. Pain sensation over the legs was impaired but temperature sensation was normal to routine tests. A brain CT scan was normal.

The acute paraplegia in this patient was probably due to infarction of the thoracic cord in the watershed zone between the anterior, circumflex and posterior spinal arteries following the rapid decrease in mean arterial blood pressure. There was no evidence to suggest a dissection of the aorta. We are not aware of any previous cases of paraplegia occurring in this setting although it has been reported following the hypotension of myocardial infarction and cardiac arrest.<sup>1</sup> The cerebral complications of rapid reduction in mean arterial blood pressure using intravenous therapy in malignant hypertension have been well documented.<sup>2</sup> This case suggests that the spinal cord, like the brain, is unable to autoregulate blood flow during rapid and extensive reductions of blood pressure in severe hypertension, and is a further reminder of the dangers of hypotensive treatment, even using oral agents.

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### AIDS and catatonia

Sir: There have been several reports of the psychiatric complications of acquired immune deficiency syndrome (AIDS). In many of these cases psychiatric symptoms antedate neurological or immunodeficiency symptoms and the only evidence for AIDS may be a positive HTLV-III.<sup>1</sup>

We report here a 19 year old hispanic male, who presented in a catatonic state and was discovered to be HTLV-III positive. The patient had no previous psychiatric history and his behaviour started deteriorating two months prior to admission into the hospital. During this time, the patient became progressively more lethargic and withdrawn, refused to speak or eat, and would remain motionless for hours at a time. Homosexuality was not confirmed but the family gave a history of a two-month incarceration one year prior to hospitalisation. At time of admission he was noted to have marked seborrhoea, mydriasis, intermittent lachrimation and oropharyngeal candidiasis. He was incontinent for faeces and urine, had a decreased gag reflex and showed increased muscular tone and brisk reflexes in all extremities. He was initially treated with 30 mg of haloperidol for two months with minimal response and a very slow clinical recovery of movement and speech. The patient remained with a residual deficit. Laboratory findings was normal. The lumbar puncture revealed no evidence of an infectious process. CT scan of the brain revealed diffuse cortical atrophy. EEG showed diffuse cortical slowing. The positron emission tomography scans showed increased blood flow and glucose metabolism in the basal ganglia (caudate, putamen) and right temporal cortex.

Acute onset of illness, lack of previous psychiatric illness, lack of a family history for psychoses along with the cortical atrophy, the cerebral metabolic abnormalities and positive HTLV-III suggest an AIDS encephalopathic process.

Damage to the CNS has been postulated to occur secondary to opportunistic infections, malignancies or from direct invasion of the CNS by the HTLV-III.<sup>2,3</sup> In some of these cases, the psychiatric features may be more prominent than the neurological ones and may occur without manifestations of immunodeficiency.<sup>4</sup> Predilection of some viruses for behaviorally related brain areas (temporal lobes, orbital frontal cortex, hippocampal gyrus) account for the high incidence of psychiatric symptoms in some patients with viral encephalitis.<sup>5</sup> Furthermore, viral encephalitis presenting with

catatonic syndrome have been found to affect mostly the limbic system (medial temporal cortex). Catatonic features have also been observed in humans in lesions of the basal ganglia.<sup>6</sup> Careful investigation of the brain areas most affected by HTLV-III may provide insight into the neuropsychiatric implications observed in the AIDS patient.

HTLV-III in cerebrospinal fluid<sup>7</sup> in conjunction with mental state examination, CT scan and EEG may help identify encephalopathy in patients at risk for AIDS.

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### Hemiballism and CT-documented lacunar infarct in the lenticular nucleus

Sir: Hemiballism is a rare condition usually due to an infarction or a haemorrhage in the contralateral subthalamic nucleus.<sup>1</sup> However, in several cases,<sup>2</sup> this nucleus has been intact at post-mortem examination. Only a few cases of hemichorea-hemiballism have been reported in which a contralateral vas-